Mental Health Services
Oversight and Accountability Commission
Position Paper
Training and Education

Saul Feldman and Deborah Lee

The major changes needed in California's mental health services and systems—changes made possible by the Mental Health Services Act (MHSA)—cannot come about without equally major changes in the mental health workforce. And the profound changes needed in the mental health workforce must go far beyond simply an increase in numbers, an increase that may be necessary but is certainly not sufficient. It has already been well documented in medical care, for example, that a larger workforce does not by itself bring about higher quality and more effective services.

The magnitude of the problems with California's mental health workforce demands a comprehensive approach, a paradigm shift in who are trained, how they are trained and retrained, by whom they are trained and in what kinds of settings the training takes place. The requirements that dictate who can engage in so-called "professional practice" and who cannot, who can provide which specific services and who cannot must also be changed. Too frequently, these requirements are unnecessarily restrictive and inhibit access for people who need help. Licensing and other practice regulations initially designed to protect the public from unqualified practitioners have instead all too frequently become a safeguard for the prerogatives of mental health professionals and the organizations to which they belong, to the detriment of good, more easily accessible care. The changes that are needed will not come easily; they will challenge strong vested interests, the conventional wisdom and an inflexible system that at every level and even with the best intentions have a substantial interest in preserving the status quo. But change we must if we are to be true to the voters in California who supported Proposition 63, to those whose tax dollars are funding it and to those who need, want and deserve effective and accessible mental health services—not the kind overly influenced and too often required by professional associations, licensing bodies and academia. The MHSA gives California the opportunity to do something that has never been done before: to build a new mental health workforce from the ground up, to develop curricula, teaching models and the like that focus on the needs of the consumer.

Recognition of the workforce problems in California and in the rest of the country is not new. Beginning at least 50 years ago, a number of prestigious commissions and expert panels made countless important recommendations meant to reform the mental health workforce, but very few have been adopted (see Appendix for a partial list). The most recent recommendations were in the 1999 U.S. Surgeon General's Report, the President's New Freedom Commission Report in 2003, and, in 2006, the report by the Institute of Medicine that as part of its workforce recommendations acknowledged the "…short-lived and unheeded commissions, expert panels, reports, and recommendations to improve the capacity and quality of the mental/substance use workforce."

The Institute report identifies as a major factor in the high mortality rate of workforce improvement recommendations, the failure to establish an ongoing body responsible to

oversee, advocate for and follow up on converting recommendations to action. The report concluded "…that the problems that attenuate the effectiveness of the mental/substance use health workforce in America are so complex that they require an ongoing, priority commitment of attention and resources, as opposed to the short-term, ad hoc initiatives that often characterized responses to the problems in the past." What has not been possible nationally is now more so in California because of the funds available for education and training through the MHSA, the collaboration of diverse stakeholders, the single state vs. national focus and the integrated approach made possible by the MHSA that includes funding for community services and support, prevention, innovation and improved technology.

The MHSA gives the Department of Mental Health (DMH) the direct responsibility for implementing the training and education component of the Act. The Act requires the DMH to identify state-wide workforce needs and create a five-year education and training plan. The plan is to be reviewed and approved by the Mental Health Planning Council (MHPC), also responsible for advising and overseeing the DMH's development of education and training policy and planning. The Oversight and Accountability Commission (OAC) reviews and oversees all aspects of the Department's performance related to the MHSA, including the effects of the Act on mental health education and training in the State. The Act mandates the OAC to oversee all "human resources" components— the activities outlined in the Education and Training Program section of the Act. The Act requires members of the OAC to be ex-officio members of the MHPC. To carry out these responsibilities, the Commission is asked to "employ … appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, not withstanding any authority expressly granted to any officer of employee of state government."

Ten percent of the funds available under the MHSA is reserved for education and training from 2005 to 2008. In any year after 2008, funds may be allocated for human resource needs, subject to certain restrictions. The funds designated for education and training remain in a trust fund until they are dispersed. According to the DMH's estimate on 1/31/2007, approximately $456 million will be available for education and training through June 2008.

Role and Responsibilities of the MHSOAC

The OAC formed an Education and Training (E/T) Committee with broad representation from experts throughout California to help fulfill its responsibility. Committee members include leaders of public and private academic and professional behavioral health organizations, consumer and family advocacy groups, public mental health programs, social rehabilitation agencies, alternative treatment programs, mental health service programs, unions and two former county mental health directors. What follows is the Committee's view of its primary responsibilities and what is needed to improve the capacity, responsiveness and effectiveness of California's mental health workforce.

The primary responsibility of the E/T Committee is to inform and advise the OAC regarding mental health workforce issues and to recommend strategies for improvement. The Committee considers its responsibilities to include the following:

- Articulate a vision for change in California's mental health workforce

- Identify California's key mental health workforce education and training issues and strategies for bringing about positive change, consistent with the values, goals and intended outcomes enumerated in the MHSA
- Ensure that the perspectives and expertise of diverse people with mental health issues and their families as well as a broad spectrum of stakeholders inform the Committee's work and all aspects of California's mental health training, education and workforce development
- Ensure that the OAC's perspective and efforts in education training are integrated into its work on the other components of the MHSA: community services and support, prevention and early intervention, innovation, technology and capital facilities
- Through the OAC, present recommendations to DMH, the MHPC, the governor, legislature, counties, diverse stakeholders and the public regarding the mental health workforce
- Work collaboratively with DMH, the MHPC, consumers and family members and other stakeholders toward consensus regarding workforce needs, principles and strategies. Ensure that these principles and strategies are reflected in five-year plans, funding guidelines and funding decisions
- Oversee and evaluate actions taken by the DMH, the counties and others in improving the mental health workforce in California to ensure fidelity with the provisions and intent of the MHSA.

Key Objectives

The OAC recognizes that two things, both important, must begin quickly and proceed together – meeting the short-term needs for a larger and more effective mental health workforce to implement the programs already being funded under the other components of the MHSA and, certainly no less important, to bring about the major changes needed at the core to transform over the longer term the mental health workforce needed in the future so that short-term approaches will no longer be necessary.

The overall goal is to enhance the competence, diversity, effectiveness and productivity of California's mental health workforce. The objectives that follow are simple to state but broad in their scope, far reaching in their effects, formidable to accomplish and faithful to the principles embodied in the MHSA. When achieved, they will have an unprecedented, enduring and profound effect on the mental health workforce not only in California but as a model for the rest of nation. They are as follows:

- Develop and implement the incentives that will motivate greater numbers of people to join the mental health workforce and remain in it, and improve the conditions and job satisfaction of those already in the workforce
- Change the composition of the mental health workforce by acknowledging that good mental health services are not solely dependent upon clinicians with graduate degrees and by creating greater opportunities for the training and employment of a much broader range of mental health workers than ever before

- Bring about changes in licensing requirements and practice restrictions that unnecessarily limit access to needed mental health services
- Increase the number of well-qualified mental health practitioners and improve their distribution throughout California
- Develop new and innovative training and education programs that will bring together people who do not seek degrees and those who do, using curricula that are competency-based, interdisciplinary, focused on consumer needs rather than those of any particular professional group and that effectively teach skills to promote recovery and resilience.

Recommendations and Approaches

Alleviate the shortages and maldistribution of mental health workers

Nationally and in California, the shortage and maldistribution of mental health workers is well documented and widely reported. Particularly severe shortages have been noted in rural areas. In addition, there are urgent shortages of mental health practitioners with skills to work with such high-need groups as children, older adults and diverse populations. It is expected that there will be an increasing demand for practitioners with these competencies. Despite substantial agreement about the nature and extent of the problems, efforts to improve the situation have been largely unsuccessful.

The MHPC estimates that the vacancy rate for mental health professional positions in California exceeds 30%. The majority of California's licensed mental health workers are located in urban settings, with nearly 70% employed in The San Francisco Bay Area, Orange, Los Angeles and San Diego Counties. A study conducted by the University of California San Francisco in 2003 estimated that the need in California for mental health services will increase between 16 and 30 percent from 2001 to 2010.

While most studies focus on documented shortages principally of licensed, mental health professionals, mental health care is also provided by unlicensed, (and largely under-recognized) people, including peers (mental health consumers and their family members), paraprofessionals and various religious, tribal and community leaders, as well as by primary care practitioners and other physicians.

Shortages of mental health practitioners are exacerbated by significant employee turnover, with annual rates estimated at between 25-50%. Turnover is expensive and has a negative effect on the quality of services, staff morale and productivity. To help address this issue, wages and working conditions must be improved as well as more skilled supervision, relevant training, realistic and flexible workloads, relief from obsolete regulations and opportunities for advancement. Sources of burnout, including stress, emotional exhaustion, demands that exceed resources, marginalization of consumers and people of color and role conflicts need to be addressed and ameliorated.

It is unlikely that traditional remedies alone, such as providing stipends, forgiving loans, etc., will be sufficient to produce the significant long-term benefits required, given limited funding, this strategy's high cost per participant and the preference of many professionals to work where they have received their training. More fundamental approaches must be considered.

Approaches to Consider

- Increase the number and quality of entry-level mental health training programs for current employees and new mental health practitioners, including non-degree, AA-degree and bachelor's-degree programs and expand their roles
- Educate mental health practitioners to work in creative partnerships with primary care and provide training and support for primary care practitioners
- Develop and implement a major public service campaign to attract people into the mental health field, with a focus on underserved communities
- Conduct an analysis of working conditions and wages for the mental health workforce and require that all practitioners be paid competitive wages and have positive working conditions
- Help mental health organizations improve their climate (employees' perceptions and emotional responses to the workplace) and culture (organizational behaviors, norms and expectations), both of which have a significant effect on turnover
- Provide supports such as housing stipends and/or preferential housing loans or sabbaticals and increased compensation to mental health practitioners who work in under-served communities
- Increase the use of evidence-based and promising practices to enhance the efficiency and effectiveness of the mental health workforce; ensure that efforts to increase practitioner efficiency recognize and support the time required for quality clinical services and relationships
- Remove the restrictions on the ability of well-trained psychiatric nurse practitioners to practice and prescribe psychoactive drugs without requiring the availability of an M.D.; this change is particularly important in rural areas where there is a severe shortage of psychiatrists and few non-psychiatrist physicians whose knowledge of psychotropic drugs is sufficiently helpful
- Increase the number of people served through a greater use of group therapy and other group approaches, taking into account the challenges posed by group members who speak different languages
- Increase the amount, usefulness and availability of web-based counseling, self-help information and resources; increase the number of people with access to the Internet
- Increase resources and build practitioners' skills in the use of telementalhealth models to expand access to mental health services, especially in rural communities throughout the State.
- Strengthen the leadership, administration and management of mental health organizations to enhance their efficiency and productivity.

Adopt and implement major changes in the graduate education of mental health professionals to improve skills and enhance outcomes

Inadequacies in the graduate education of mental health professionals, and related deficits in practitioners' skills, have been well documented and present formidable barriers to change. The content of current mental health graduate training, for example, is not sufficiently responsive to consumer needs. Too much of what is required in the curricula is influenced by professional guilds, licensing requirements and academic inertia, is not sufficiently relevant to practice and therefore rarely used again. Problems in graduate training are numerous and include the following:

- Graduate training of mental health professionals is characterized by seemingly impenetrable single-discipline silos, despite the growing recognition that the most effective interventions are cross-cutting and integrative. There is little interdisciplinary training and psychologists, psychiatrists and other mental health professionals are not exposed to the advances made in fields other than their own
- There is no agreed-upon competency-based core skill set or knowledge base for mental health practice that is incorporated into training programs; individual efforts to define competencies have not evolved into consensus frameworks or models
- Competencies needed for recovery-based mental health practice have not been widely adopted. Practitioner skills to support resiliency, recovery and collaboration–the hallmark of the MHSA–are featured in too few training programs
- Practitioners are not taught to work effectively with 'non-traditional' providers of mental health services, including primary care. This is important since most people who seek help for mental health problems, especially people of color and older adults, do so from their primary care physicians, who prescribe by far the majority of psychotropic medications and are not sufficiently prepared to do so
- While mental health professionals are charged by licensing requirements and professional standards to work within their areas of competency, few mechanisms are in place to verify the competencies of individual practitioners
- Training programs do not focus sufficiently on collaborative treatment planning, quality improvement strategies, or explicit outcomes for consumers
- Insufficient emphasis is placed in training on technologies such as telementalhealth and the use of the Internet to make services more accessible and promote self-help
- While 'cultural competency' is often included in training programs, there are few ways to ensure that practitioners are willing and able to apply the requisite knowledge and skills
- Few programs utilize teaching methods that have proven efficacy.

Making the needed significant changes in mental health education and training, especially at the graduate level, is a formidable challenge. Resistance to change is strong – the training gaps described here have been documented for at least 25 years. It is important to

identify institutions that may be receptive to change and/or those that have initiated change, and provide incentives to motivate and support them. It is also important to fund, on a pilot basis, new interdisciplinary programs that use effective teaching methods to teach the knowledge and skills essential to a skilled, effective mental health workforce. Transformation of the mental health workforce will require dramatic changes in who is trained and what is taught.

As a result of the problems with training and education, too many clinicians lack core skills. Despite varied efforts to define mental health competencies, there is not yet substantial agreement on how to define, contextualize and assess competencies. In addition, there are widespread shortages of specific skill sets, such as prevention and early intervention, group therapy, family therapy and treating co-occurring mental health and substance-use disorders. Many clinicians are not taught to collaborate with and learn from consumers and family members: for example, providing information about treatment options, making treatment decisions jointly, supporting self-help and advocacy and helping people address their material and survival needs.

There continues to be a serious lack of cultural and linguistic competency in the mental health workforce, resulting in poor assessments, misdiagnoses, inappropriate treatment plans, inadequate and inaccessible services, as well as burnout for those staff with knowledge and skills to serve consumers and family members from diverse communities and who speak diverse languages. This is a particularly urgent problem in California, where 29% of non-English speakers in the U.S. live despite being home to only 12% of the country's overall population and where residents speak 48 Asian/Pacific Islander languages. Over 25% of California legislative districts have a majority of residents who speak a language other than English at home. California ranks first in the United States in the percentage (20% of the general population and 25% of the school-age population) of its population that has difficulty speaking English; an estimated 40% of Californians speak a language other than English at home.

Approaches to Consider: Practitioner Training and Skills

- Articulate and require standards for training and retraining mental health practitioners in desired skill sets, including curricula and teaching methods
- Develop, identify and teach culturally competent and recovery-oriented approaches to mental health practice at all levels, including prevention, outreach, engagement, assessment, diagnosis, treatment planning, service delivery and evaluation; teach practitioners to address the self-defined needs of their clients
- Identify and support those graduate education and training programs that have demonstrated successful practices and positive outcomes and provide incentives for others to do so
- Develop new approaches such as a California Academy of Mental Health in which people of all levels who aspire to work in the mental health field are trained together, from non-degree certificate programs through graduate degrees in mental health. People who are trained together are more likely to work well together and cross-fertilization can be a valuable teaching tool. The curricula for each level of intensity would be built from the ground up, focused on the core competencies required for effective mental health services and drawing on state-

of-the-art knowledge from biology, psychology, social science, the experience of diverse mental health consumers and their families and mental health practitioners.

- Utilize teaching methods that have demonstrated the capacity to increase skills and promote positive outcomes, with an emphasis on interdisciplinary, applied, experiential and didactic teaching/learning methods
- Offer increased opportunities for trainees to learn in settings where they will eventually practice, including community-based settings and settings that have not traditionally been defined as mental health; increase the "real world" focus in graduate training
- Increase the supply of skilled faculty, especially those actively practicing the skills they teach; reward excellence in teaching
- Identify and require demonstration of core competencies for all mental health clinicians, across licenses and link competencies to outcome
- Develop and disseminate competencies that support prevention, wellness and resilience, from diverse cultural perspectives
- Increase practitioner competencies in non-clinical skills such as information technology, data analysis, working with managed care and other third-party systems, administration, leadership, etc.
- Define standards and competencies for training supervisors; create systems of accountability to track supervisors' behavior and its impact on people they supervise
- Define and communicate standards and competencies for trainers.

Make fundamental changes in licensing and continuing education

California's professional mental health licenses vary substantially by discipline in their requirements for education, supervision, continuing education and approaches to demonstrating competency. They do not sufficiently focus on the knowledge and skills most relevant to practice. All require supervised experience, e.g., internships but they differ in amount, the settings in which the supervision takes place, type and other characteristics.. Few if any require demonstrated skills to support recovery and resiliency, work across disciplines, mitigate the consequences of serious mental illness, focus on and document clear outcomes, or other approaches that are essential to successfully implementing the MHSA. And although most licensing boards require course work in such useful areas as ethics, substance-use disorders, working with older adults and domestic violence, these are not consistent across licenses and are not sufficiently relevant to practice.

Most continuing education relies on one-time didactic lectures, workshops, or conferences; none of these methods have demonstrated efficacy in improving practitioner performance or consumer outcomes. Skills related to recovery, resilience, wellness and supporting consumer- and family-led efforts are generally not featured in continuing education programs, and opportunities for practitioners to learn from consumers and family members are very limited.

Approaches to Consider

- Convene a group of experts to engage in a comprehensive review of all California mental health licenses – requirements for new and continuing licensure, procedures, effects on clinician performance and relevance to effective practice
- Make the demonstration of skills a foundational requirement of new and ongoing licensing, certification and continuing education; competencies should focus on behavior, in addition to knowledge and skills
- Adopt an inter-disciplinary approach that requires demonstration of core competencies among the disciplines, with additional competencies required for certification in areas of specialty practice
- Include more opportunities for active learning in public mental, community-based and cross-system settings as a precursor to licensure and for continuing education
- Improve continuing education by expanding content guidelines, adding required courses in areas of MHSA priority, diversifying teaching methods, creating opportunities for more active and individualized learning, involving diverse consumers and family members and more rigorously assessing course offerings and outcomes.

Increase the number of consumers and family members employed in the mental health workforce

Employment of mental health consumers and their family members is a requirement of the MHSA. Consumer/family employment is essential to improve services and also is an important element in recovery. Qualified consumers and family members need opportunities to contribute across the entire range of roles and responsibilities, including outreach and engagement, direct services, peer support and peer counseling, evaluation, training, technical assistance, policy development, advocacy and management.

Progress is being made. According to a 2003 study conducted by the MHPC, 86% of the counties employ at least one self-identified consumer or family member, including those in civil service positions as well as in contracted community-based agencies. Most (75%) work part-time. DMH estimated in a study conducted in 2006 that 20% of the new MHSA positions created statewide by counties through their community services and support funding were specifically designated for consumers and family members.

A number of strategies have been identified to support the successful integration of consumers and family members into the mental health workforce. One important need is for training. Despite the critical role they can play in providing mental health services and supports, consumers and family members do not frequently enough receive sufficient mental health training. The training they do receive is fragmented and the programs that exist are not sufficiently coordinated. Further, the transition to employment is made more difficult by the limited availability of part-time jobs, potential loss of benefits and other issues. Many strategies that support increased employment of consumers and family members can also facilitate increasing the range of people in the mental health workforce, including those without graduate degrees or professional licenses.

Approaches to Consider

- Give priority to hiring consumers and family members at all levels, including administration
- Change practice and employment requirements that are unnecessarily restrictive about who can provide mental health services
- Proactively recruit consumers and family members as trainers to the mental health workforce in order to convey the actual experience of illness, treatment and recovery and promote more effective practices
- Train and support consumers entering the mental health workforce
- Develop training programs that grant certification for consumers and other who complete the requirements
- Coordinate existing training programs and develop common competence-based curricula
- Train and support existing staff and leaders in the mental health workforce to welcome consumers and family members and to create positive collaborative relationships that respect and utilize different realms of expertise
- Create a central registry and resources to link consumers and employers with job opportunities, including support for both
- Prioritize involvement and leadership of consumers and family members in the development of regional workforce collaboratives
- Support people transitioning from consumers to employees of mental health organizations, including more part-time work options, workplace accommodations, counseling and accommodations related to benefits and help with role transitions.

Increase the diversity of the mental health workforce

People of color, the majority (53%) in the State, continue to increase in their proportion of the population. Nonetheless, California's mental health workforce lacks diversity and does not reflect the population served or those with unmet service needs. Although exact numbers for the racial and linguistic backgrounds of the statewide mental health workforce are lacking, it is clear that non-white providers are not represented in proportion to their numbers in the population. A 2000 study of California psychiatrists reported that only 8% were Asian or Pacific Islander and 5% were African American or Hispanic. Fresno, home to 22,456 Hmong residents (according to the 2000 Census), had in 2006 only three licensed Hmong mental health practitioners.

It is a nationwide problem as well; nationally minorities make up approximately one-fourth of the population but only 10% of mental health providers. In the country as a whole, it is estimated that while about a third of the population consists of ethnic minorities, over 90% of psychologists, social workers and family therapists are non-Hispanic whites; 65%-71% are women. African Americans are less than 4% of the U.S. mental health workforce. The ratio of Asian Amercan mental health providers to U.S.

Asian American populations is about half the ratio for whites; the implications of this disparity are complicated by the fact that the term "Asian American" comprises at least 43 different ethnic groups. It is estimated that less than 1% of U.S. psychologists are Hispanic. There are approximately 29 Latino mental health professionals for every 100,000 Latinos in the United States, compared to 173 Caucasian mental health professionals per 100,000 Caucasians in the population.

An urgent priority is for the mental health workforce to reflect California's population in language, race and culture, and also increase its competence to work successfully with people from diverse backgrounds. The New Freedom Commission calls for the mental health workforce to include "individuals who share and respect the beliefs, norms, values and patterns of communication of culturally diverse populations." According to the president of the California Wellness Foundation, "a significant body of research indicates that a workforce that more closely mirrors the racial and ethnic diversity of our state will increase access to care and improve the quality of care that is delivered." A mental health workforce reflecting consumers in race and language encourages people to enter, participate in and profit from treatment. There is also evidence that experiences associated with exclusion, racism and lack of control have significant and negative mental health effects. The experiences of immigrants and, especially, of refugees have significant potential for mental health consequences. These issues are more likely to be understood by practitioners with similar experiences, and also must be addressed effectively by all mental health practitioners.

Many people of color in California are immigrants or refugees, with additional risks for mental health problems as well as strengths from family and cultural supports. For example, many refugees have experienced war, trauma, displacement, and separation from family members, in addition to psychosocial and environmental problems in the host country that negatively affect their mental health –including re-traumatizing violence. Immigrants frequently must cope with an array of issues: for example, different levels of English proficiency and acculturation among generations within families, a sense of separation from both the original and new culture, and/or instability and marginality from undocumented status. It is an urgent need to recruit and employ as mental health practitioners immigrants and refugees, who understand experientially the needs of people who have undergone such experiences.

It is particularly important to provide mental health services in languages spoken by consumers. In a 2006 analysis by the California Department of Mental Health, counties identified culturally and linguistically diverse mental health practitioners as among their most urgent workforce needs.

The priority for a mental health workforce that reflects the population is not a substitute for increasing all practitioners' cultural and linguistic competence to work effectively with diverse individuals and communities. The Annapolis Coalition on the Behavioral Health workforce has described this as a "crisis point" and the MHPC has called it "one of the most urgent issues facing the mental health system."

Approaches to Consider

- More actively recruit and support people of color, from diverse backgrounds and those who speak languages other than English, including immigrants and refugees, for all levels of mental health training programs (non-degree through licensed professionals)
- Ensure that consumer and family involvement at all levels, including education and training, reflect California's diversity; actively reach out to consumers and family members from underserved communities
- Increase the number of practitioners, especially people of color, who provide mental health services and supports in non-traditional settings.
- Increase educational, emotional and practical support and mentoring for people of color and bilingual/bicultural people at all levels of the mental health educational system, internships and workforce, including financial supports
- Collect more adequate baseline information regarding race, ethnicity and language capability of mental health practitioners, broadly defined
- Increase pay and reduce caseloads for bilingual mental health professionals
- Provide more financial incentives to motivate an increase in the number of bilingual training programs and trainees
- Ensure that leaders in California mental health reflect the state's diversity, and that they have the necessary skills to manage and support a diverse workforce
- Give priority to educational and advancement opportunities for people of color currently in the mental health workforce who want to increase their skills and contributions
- Increase the quality of education for students of color in mental health training programs by diversifying the faculty and broadening the content of the curriculum to reflect diverse approaches and values
- Conduct community outreach and marketing campaigns to improve the image of mental health professions in diverse communities

Strengthen the leadership and administration of mental health organizations

Effective leadership is one of the keys to organizational excellence and a critical element in successfully implementing the MHSA. This is particularly the case because the majority of people with serious mental illness are seen in organizations of one form or another rather than in solo private practice.

Leadership is required to create and sustain organizations that achieve positive outcomes, continuously assess and improve services and replicate the most effective strategies and interventions. Leaders are essential to creating positive organizational environments in which a diverse, transformed workforce can learn continuously and thrive, and where they will be motivated to continue working. Effective management and supervision of

mental health treatment teams is positively associated with consumer satisfaction, quality of life and enhanced productivity.

California's mental health leaders at all levels must master many roles, negotiate uncertain and constantly shifting boundaries and address the needs of a wide range of constituents and funding sources, while advocating for and implementing change. Particular challenges facing California's mental health leaders include the following:

- After decades of under-funding and "fail first" policies, there is insufficient infrastructure to properly support mental health organizations.
- Mental health leaders who are clinicians that have advanced through the ranks are not necessarily well versed in the leadership and administrative skills essential to effective organizations. Non clinician leaders may not be sufficiently cognizant of the special needs and characteristics of the mental health organization and the environment in which it operates.
- Research demonstrates that practitioners' perception that their leaders and supervisors are supportive is critical for workforce retention.
- A critical need of the new mental health workforce is for people from diverse backgrounds and perspectives to work together effectively, supporting each other and making good use of each other's expertise; this challenge requires strong leadership.
- Most training workshops are primarily motivational; actual skill development occurs after the workshop, when trainees implement new practices such as those supporting recovery, resilience and cultural competency. It is essential that supervisors and organizational leaders support these new practices inspired by training or little will be accomplished.
- People who enter the mental health workforce, at all levels, including consumers and family members, need career pathways that include the potential to rise to leadership positions.
- There are few training programs in mental health administration, either free-standing, part of graduate training in the mental health professions or in schools of public health, public administration and business administration.

The mandate for California's mental health leaders, including consumers and family members, is to provide the vision and skills required to create and maintain organizations that prioritize recovery, resilience and cultural competency, and extend effective services to communities whose needs are not currently being met. To transform the California mental health system in ways envisioned by the MHSA, it is essential to educate and strengthen mental health leadership at all levels. Research indicates that state directors of mental health, for example, perceive a need for increased skill development in the areas of management and leadership. Leadership training is likely to bring about increased efficiency in the mental health workforce, and greater productivity, making better use of limited funds.

Approaches to Consider

- Develop and pilot educational programs and pathways for people who want to become leaders and administrators of mental health organizations and help expand those programs that may already exist
- Develop programs specific to mental health administration within existing graduate programs in health, public and business administration and as a specialty area in psychology, psychiatry, social work etc.
- Provide training in oversight and accountability for board members of non-profit mental health organizations that provide services in the public sector
- Support leadership training programs for consumers and family members who want to assume or expand leadership positions in mental health organizations
- Provide opportunities for line mental health workers to expand leadership skills
- Support public and private mental health leaders who are incorporating new programs and relationships into their service delivery systems so they can create organizations that support effective practice
- Train supervisors to increase their management skills.

Increase the adoption rate of practices that demonstrate positive outcomes

According to the MacArthur Foundation, "No longer is there a question about whether effective treatments for mental illnesses exist. They do. The challenge now is to move past the barriers to seeking and receiving treatment and to bring the results of research to the service of those in need around the world." The 2006 Institute of Medicine report notes that "there continues to be a large gap between what is known, what is taught and therefore what is done in practice."

This gap includes evidence-based practice and practice-based evidence–two approaches to demonstrating that specific interventions lead to positive outcomes. Evidence-based practice can be defined as approaches that have been proven through research, ideally randomized trials, to deliver a desired result. Practice-based evidence requires a systematic effort to understand and monitor the experiences of consumers and practitioners with regard to what works best in a particular treatment or service to bring about positive outcomes. Both of these approaches have imitations but both have much to offer as practice and research continue to inform and enrich each other. Neither approach is yet sufficiently taught in clinical graduate training programs, and there are very low rates of adoption by most mental health practitioners. To be successful, both require a therapeutic alliance between the consumer and the clinician.

The use of strategies that enhance recovery and resilience has great potential benefits for consumers and their families. A population-based survey indicated that only 25% of respondents with a serious mental illness received treatment consistent with evidence-based guidelines. Research indicates that low confidence in the outcome of therapeutic services is a major deterrent to seeking care.

Consumers, family members and some clinicians express serious concerns that evidence-based practices are too limited, that they encourage 'cookie-cutter' care and preclude

practices that are experienced as successful but have not been tested scientifically. Much of the research on evidence-based practices was conducted before the emergence of a recovery vision for mental health, and does not sufficiently address this orientation. For these and other reasons, it is also important to emphasize and teach practice-based evidence and promising strategies.

Approaches to Consider

- Provide incentives for professional and other practitioner training and education programs, including continuing education, to teach approaches that have demonstrated positive outcomes, specific to age, race, gender, culture, sexual orientation and other relevant factors
- Identify the outcomes that consumers and/or their family members desire and teach the skills that promote these outcomes
- Expand research and use of practice-based evidence to include recovery and resilience outcomes defined by diverse consumers (as opposed to traditional definitions such as hospital relapse, length of stay, or symptomatology); examples of recovery outcomes include self-acceptance and confidence, empowerment, life satisfaction, improved relationships and social support and participation in meaningful roles and activities
- Teach skills and provide resources to practitioners to help them assess what practices are and are not working, including ongoing assessment of consumers' satisfaction with the therapeutic relationship and their perceptions of the outcomes of treatment and other interventions
- Teach practitioners to practice in ways that are likely to have a positive impact on system-level outcomes: for example, to eliminate disparities in mental health services.

Increase the emphasis on prevention and early intervention in workforce training programs

A key priority in the MHSA is prevention and early intervention, for individuals, families and communities. Not only is this a discreet area of emphasis for designated funding, the Act envisions that the mental health system as a whole will move toward prevention and early intervention: "help first" rather than "fail first." This desired change is hampered by a lack of emphasis in most training programs on prevention, early intervention and strength-based approaches. There has been relatively little emphasis nationally on this dimension of workforce development, with the exception of substance-use disorders.

Approaches to Consider

- Identify and gain consensus on core competencies in mental health prevention/promotion and early intervention
- Teach and provide opportunities for practitioners/trainees to practice effective prevention and early intervention strategies: for example, to identify and build on strengths, combat stigma, enhance natural and community networks, support and advocate for consumer and family members, develop collaborative goals, support traditional and community healing practices, help people mobilize concrete

resources and practice other critical skills associated with prevention and community education

- Enhance practitioners' skills to work in and collaborate with diverse community settings and services, including education, medical care, social services, housing, criminal justice/probation, youth programs, elder programs and residences and faith-based organizations
- Strengthen practitioners' ability to reach out to diverse people with mental health concerns, build trust and mutual respect and create alliances, often by going to where people are
- Increase the number of access workers located in a variety of settings, who offer a friendly ear, support, assessment, service navigation and coordination, information, personalized referrals and self-help/social support strategies
- Enhance practitioners' skills in helping low-income consumers address economic and survival issues, including homelessness, unemployment, poor housing and experiences of violence and trauma that are risk factors for mental illness and for worse outcomes from mental illness
- Increase understanding of biological, psychological and social underpinnings of psychological well being and psychological disorder, including emerging research on the brain and neurobiology
- Identify, train and support community-based practitioners in diverse settings who are in a position to identify early signs of mental illness and provide positive interventions
- Train and provide technical assistance to physicians, parents, school personnel and others in the community to help them identify and intervene positively with people who may be showing early signs of a potential mental disorder.

Create a sustained commitment to bring about changes in the mental health workforce

As described earlier, numerous and noteworthy recommendations to transform the mental health workforce have not led to lasting or significant change. According to the Institute of Medicine, successfully addressing mental health workforce challenges requires ongoing, broad-based effort.

In order to bring about fundamental changes, a highly visible, centralized, enduring structure is needed to stimulate and coordinate a range of essential resources.

Approaches to Consider

- Authorize MHSA funds for a Council to support the fundamental changes needed in California's mental health workforce. This body should include representatives from consumer and family groups, the MHSOAC, DMH, MHPC, County Mental Health Directors Association, California Institute of Mental Health, academia at all levels, regional workforce collaboratives, primary care, mental health practitioners, licensing boards and other stakeholders. The purpose of this Council would be to create, implement, evaluate and oversee a comprehensive plan to

strengthen the quality and capacity of the mental health workforce, to bring about and help maintain the needed changes, and thereby to improve mental health outcomes in California. The Council would serve a variety of purposes, for example:

- Address and resolve policy issues relevant to changing the mental health workforce
- Ensure that curricula, including required competencies, are updated and emerging strategies, knowledge and resources are disseminated and made available to people in the field, to support a continuously educated mental health workforce
- Create a sustained source of MHSA funding for mental health workforce development after fiscal year 2007-2008
- Coordinate efforts to leverage additional resources to strengthen the mental health workforce
- Collaborate with other California efforts, such as the Employment Development Department's one-stop employment centers for persons with disabilities
- Evaluate the extent to which needed changes and progress are being made
- Issue periodic reports on progress and on issues that need to be addressed
- Continue to promote and advocate for needed changes
- Provide centralized support for developing local, regional and statewide mental health workforce collaboratives.

Conclusion

There are no greater barriers to fulfilling the objectives and vision of the MHSA than those now evident in California's mental health workforce. Successful implementation of the Act and therefore the transformation of mental health services in California are simply not possible without a workforce accessible to California's diverse communities— one with the knowledge, resources, skills and commitment to provide responsive and effective services. Such a workforce does not now exist in sufficient numbers. Change will require training and support for existing workers, infusion of new workers, effective leadership, new ideas, greater resources and a transformed and expanded educational and training capacity. It will also require a willingness to challenge the conventional wisdom, the inertia and the vested interests that for too long have prevented Californians from getting the mental health services they need and deserve.

Appendix – Partial List of Past Workforce Recommendations

- The American Psychiatric Association Committee on Medical Education, 1956
- The final report of the Joint Commission on Mental Illness and Health: *Action for Mental Health*, 1961
- The National Association of Alcohol and Drug Abuse Counselors, 1972
- The Association for Medical Education and Research in Substance Abuse, 1976
- The President's Commission on Mental Health, 1978
- Institute of Medicine, 1990, 2003 and 2006
- Substance Abuse and Mental Health Services Administration (SAMHSA), 1993, 2000, 2002, 2005
- U.S. Surgeon General, Department of Health and Human Services, 1999
- Annapolis Coalition, a program initiated in 2001 by the American College of Mental Health Administration
- President's New Freedom Commission on Mental Health, 2003.

References

Aarons GA & Sawitzky AC. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. *Administration and Policy in Mental Health and Mental Health Services Research* 33, 289-301.

Annapolis Coalition. (2006). Cultural competency and disparity in access to quality services. Available at http://www.annapoliscoalition.org/cultural_competence.php.

Anthony W. (2005). *Principled Leadership in Public Mental Health.* Webcast aired Nov. 22, 2205. Available at http://www.bu.edu.cpr/webacast/eaderships.html.

Anthony W, Rogers ES, & Farkas M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal* 39, 101-114.

AsianPacific American Legal Center of Southern California. (2006). California Speaks: Language Diversity and English Proficiency by Legislative District. Asian and Pacific Islander American Health Forum. Available at http://apalc.org/demographics/wp-content/uploads/2006/09/apalc_californiaspeaks.pdf.

California Board of Registered Nursing. (2001). Frequently asked questions regarding nurse practitioner practice. State of California Department of Consumer Affairs. Available at http://www.rn.ca.gov/practice/pdf/npr-i-25.pdf.

California Mental Health Planning Council. (2002). Expanding the Use of Psychiatric Nurse Practitioners in Behavioral Health Settings: Resource Materials. Available at http://www.dmh.cahwnet.gov/MHPC/docs/expand-nurse.pdf#search=%22expanding%20psychiatric%20nurse%20practitioner%20california%20mental%20health%20planning%20council%22.

California Mental Health Planning Council. (2001). Report on mental health professional shortage area designation. Available at http://www.dmh.cahwnet.gov/MHPC/docs/MHPSA-Report.pdf#search=%22california%20mental%20health%20planning%20council%20shortage%20area%20designation%22.

California Mental Health Planning Council. (2003). Consumer and Family Member Employment in the Public Mental Health System. October, 2003.

California Wellness Foundation. (2006). The California Wellness Foundation Launches $1 Million Campaign To Increase Diversity of Health Care Workforce. Available at http://www.tcwf.org/news_archive/jan_27_06_pub_education.htm.

Christensen H, Griffiths KM, Jorm AF. (2004). Delivering interventions for depression by using the internet: randomised controlled trial. *British Medical Journal* 328, 265.

Chung H & Yamey G. (2003). Improving the mental health of Asian Americans. *BMJ* 10, 601-602. Available at http://www.bmj.com/cgi/reprint/bmjusa.02110007v1.pdf.

Clay R. (2004). The workforce crisis: SAMHSA'S response. *SAMHSA News* 12, 5-7.

Corrigan PW, Lickey SE, Campion J. & Rashid F. (2000). Mental health team leadership and consumers' satisfaction and quality of life. *Psychiatric Services* 51, 781-785. Available at http://psychservices.psychiatryonline.org/cgi/reprint/51/6/781.

Coyne J, Fechner-Bates S, et al. (1994). Prevalence, nature, and comorbidity of depressive disorders in primary care. General Hospital Psychiatry 16:267-276.

Daniels AS & Adams N. From Policy to Service: *A Quality Vision for Behavioral Health Using the Quality Chasm and New Freedom Commission Reports as a Framework for Change.* American College of Mental Health Administration.

Department of Mental Health. (2006). MHSA Education and Training Component: Workforce Education and Training Five-Year Plan, Second Draft. 9/18/2006.

Derrig-Palumbo K & Zeine F. (2005). *Online therapy: a therapist's guide to expanding your practice.* New York: WW Norton.

Dower C. (2005). Bilingual proficiency among California's health care professionals. The Center for the Health Professions. University of California, San Francisco. Available at http://www.futurehealth.ucsf.edu/pdf_files/Bilngual%20Proficiency%202005.pdf.

Epstein RM & Hundert EM. (2005). Defining and assessing professional competence. *JAMA* 287, 226-235.

Falender C. (2005). Developing and enhancing supervisory skills: A competency-based approach. Paper presented at the 113th Annual Convention of the American Psychological Association, August, 2005, Washington, DC. Available at http://cfalender.com/.

Feldman S. (1978). Promises promises or community mental health services and training: ships that pass in the night. *Community Mental Health Journal* 14: 83-91.

Flaskerud JH & Liu PY. (1991). Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Mental Health Journal* 27, 31-42.

Foti ME, Bartels SJ, Merriman MP, Fletcher KE, & Van Critters AD. (2005). Medical advance care planning for persons with serious mental illness. Psychiatric Services 56: 576-584.

George G, Sleeth RG, & Sliders MA. (1999). Organizing culture: Leader roles, behaviors, and reinforcement mechanisms. *Journal of Business and Psychology* 13, 545-560.

Goldman LS, Nielsen NH, & Champion HC. (1999). Awareness, diagnosis, and treatment of depression. *Journal of General Internal Medicine* 14, 569-580.

Hendricks T & Tucker J. (2006). Influx of English learners a challenge for California. San Francisco Chronicle, November 29, 2006. Available at http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2006/11/29/MNG86MLRUU1.DTL.

Hilty DM, Yellowlees PM, Cobb HC, Bourgeois JA, Neufeld JD, & Nesbitts TS. (2006). Models of telepsychiatric consultation—liaison service to rural primary care. *Psychosomatics* 47, 152-157.

Hoge MA, Hury LY, & O'Connell MJ. (2003). Best practices in behavioral health workforce education and training. Available at http://72.14.253.104/search?q=cache:_6PjqGN6JOEJ:www.annapoliscoalition.org/pdfs/best_practices_manuscript.pdf+michael+hoge+best+practices+behavioral+health+workforce+education+training&hl=en&gl=us&ct=clnk&cd=1&client=firefox-a

Hoge MA & Morris JA. (2003). Behavioral Health Workforce Education: An Essential Element of Sustainable Reform. Annapolis Coalition on Behavioral Health Workforce Education. February 5, 2003.

Hoge MA, Tondora J, & Marrelli AF. (2005). The fundamentals of workforce competency: implications for behavioral health. *Administration Policy in Mental Health* 32, 509-531.

Hogg Foundation for Mental Health. (2006). Cultural adaptation: providing evidence-base practices to populations of color. Hogg Foundation. Austin, TX. Available at http://www.hogg.utexas.edu/programs_cc.html.

Hyde PS, Falls K, Morris JA, & Schoenwald SK. (2003). Turning Knowledge into Practice: A Manual for Behavioral Health Administrators about Understanding and Implementing Evidence-Based Practices. The Technical Assistance Collaborative, Inc., The American College of Mental Health Administration. Available at http://www.openminds.com/indres/ebpmanual.pdf#search=%22turning%20knowledge%20into%20practice%20manual%20behavioral%20health%20administrators%22.

Little Hoover Commission. (2000). *Being There: Making a Commitment to Mental Health*. Sacramento, CA.

Institute of Medicine. (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. The National Academies Press: Washington DC.

MacArthur Foundation. (2005). Mental health in America—bringing the best of research to practice and policy. Newsroom Newsletters: News from MacArthur, December 16, 2005. Available at http://www.macfound.org/site/apps/nl/content2.asp?c=lkLXJ8MQKrH&b=1135955&ct=1738907.

Manderscheid RW, Henderson MJ, Brown DY. (2001). Status of national accountability efforts at the millennium. In Manderscheid RW, Henderson MJ, eds., *Mental Health, United States, 2000.* DHHS Publication number: (SMA) -1-3537. Washington, DC: The George Washington University National Health Policy Forum.

McRee T, Dower C, Briggance B et al. (2003). *The Mental Health Workforce: Who's Meeting California's Needs?* California Workforce Initiative, Cenber for Health Professions, San Francisco: University of California.

Mentality. (2002). Mental health improvement: what works? A briefing for the Scottish Executive. Scottish Executive and Mentality. Available at http://72.14.203.104/search?q=cache:HHbO9hjJiygJ:www.wellscotland.info/uploads/file.php%3Fserve%3D1134577374-MHI-WhatWorks.pdf%26action%3Ddownload+mentality+mental+health+improvement+what+works+briefing+scottish+executive&hl=en&gl=us&ct=clnk&cd=1.

Miller SD, Mee-Lee D, Plum B, & Hubble MA. (2005). Making treatment count: client-directed, outcome-informed clinical work with problem drinkers. *Psychotherapy in* Australia 11, 42-56.

Mohr DC, Hart SL, Julian L, Catledge C, Honos-Webb L, Vella L, & Tasch ET. (2005). Telephone-administered psychotherapy for depression. *Archives of General Psychiatry* 62, 107-114.

Institute of Medicine. (2006). Increasing workforce capacity for quality improvement. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC: The National Academies Press.

National Panel for Psychiatric-Mental Health Nurse Practitioner Competencies (2003). Available at http://www.aacn.nche.edu/Accreditation/psychiatricmentalhealthnursepractitionercopetencies/FINAL03.pdf#search=%22phoenix%20psychiatric%20nurse%20practitioner%22.

New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America.* Final Report. DHHS Publication Number: SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.

O'Connell MJ, Morris JA, & Hoge MA. (2004). Innovation in behavioral health workforce education. *Administration and Policy in Mental Health* 32, 131-165.

Padgett D, Patrick C, Burns B, & Schlesinger H. (1994). Ethnicity and the use of outpatient mental health services in a National Insured Population. *American Journal of Public Health* 84: 222-226.

Phillips SD & Allred CA. (2006). Organizational management: What service providers are doing while researchers are disseminating interventions. *Journal of Behavioral Health Services and Research 33*, 156-175.

Phoenix B. (2006). Optimizing the nursing contribution to community mental health. Presentation to the Bay Area Mental Health Workforce Collaborative.

Pincus HA, Tanielian TL, Marcus SC, et al. (1998). Prescribing tends in psychotropic medications: primary care, psychiatry, and other medical specialties. *Journal of the American Medical Association* 279, 526-531.

Rankin J. (2005). *Mental Health in the Mainstream.* London Institute for Public and Policy Research.

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, and Goodwin FK. (1993). The de facto U.S. mental health and addictive disorder service system: Epidemiologic catchment area prospective one-year prevalence rates of disorders and services. *Archives of General Psychiatry* 50: 85-94.

SAMHSA. (2006). SAMHSA Issues Consensus Statement on Mental Health Recovery. United States Department of Health and Human Services. Available at http://www.samhsa.gov/news/newsreleases/060215_consumer.htm.

SAMHSA. (2004). SAMHSA's Minority Fellowship Program. United States Department of Health and Human Services. Available at http://mentalhealth.samhsa.gov/publications/allpubs/NMH02-0143/default.asp.

Saggesse ML. (2005). Maximizing treatment effectiveness in clinical practice: an outcome-informed collaborative approach. Families in Society: *The Journal of Contemporary Social Services* 86, 558-564.

Shepherd M. (1991). Primary care psychiatry: The case for action. *British Journal of General Practice* 41:252-255.

Site visit and working meeting with the Mental Health Oversight and Accountability Commission. (2006). Available at http://www.calendow.org/reference/publications/pdf/disparities/hmong/Hmong_Fresno_Ctr_Site_Visit_new_arrivals_mental_health.pdf.

Sluyter GV. (1995). Mental health leadership training: a survey of state directors. *Journal of Mental Health Administration* 22: 201-204.

The Sullivan Commission. (2004). Missing Persons: Minorities in the Health Professions. The Sullivan Commission on Diversity in the Healthcare Workforce. Available at http://www.jointcenter.org/healthpolicy/docs/SullivanExecutiveSummary.pdf.

U.S. Census. (2000). U.S. Census Bureau. Available at http://www.cpehn.org/democharts.php?ethnicityid%5B%5D=99&btn_search.x=50&btn_search.y=18.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville: MD.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General.* Rockville, MD: Department of Health and Human Services.

U.S. Department of Health and Human Services. (2006). The rationale for diversity in the health professions: a review of the evidence. Health Resources Services Administration. Available at http://bhpr.hrsa.gov/healthworkforce/reports/diversity/default.htm.

Wagner EH, Austin BT, and VonKorff M. (1996). Organizing care for patients with chronic illness. *Millbank Quarterly* 74, 511-544.

Wallerstein RS. (Ed.) (2001). The Doctorate in Mental Health: An Experiment in Mental Health Professional Education. University Press of America, Inc: Lanham, MD.

Wang PS, Berglund P, & Kessler RC. (2000). Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine* 15: 284-292.

Waters R. (2003). The diversity gap in psychotherapy. *Psychotherapy Networker*, Sept/Oct 2003.

WHO. (2001). *Mental Health – New Understanding, New Hope*. World Health Organisation.

Ying Y & Hu L. (1994). Public out-patient mental health services: use and outcome among Asian Americans. *American Journal of Orthopsychiatry* 64: 448-455.

Young AS, Klap R, Sherbourne CD, & Wells KB. (2001). The quality of care for depressive and anxiety disorders in the United States *Archives of General Psychiatry* 58:55-61.

Zlotnik JL, DePanfilis D, Daining C, & Lane MM. (2005). Factors influencing retention of child welfare staff: a systematic review of research. *A Report from the Institute for the*

Advancement of Social Work Research. Available at http://www.charityadvantage.com/iaswr/images/FinalReportCWWI.pdf#search=%22mental%20health%20loan%20forgiveness%20stipend%20data%20CALSWEC%22.